STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505463	A. BUILDING _____ B. WING _____	C 10/04/2013

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SUNRISE VIEW CONVALESCENT CTR	2520 MADISON EVERETT, WA 98203

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F 000	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at Sunrise View Convalescent Center on 9/30/13 and 10/4/13. A sample of 5 residents was selected from a census of 49. The following were complaints investigated as part of this survey: 2863911 The survey was conducted by: [redacted], RN, MSN The survey team is from: Department of Social and Health Services Aging and Long Term Services Administration Residential Care Services, District 2 A 3906 172nd Street NE, Suite 100 Arlington, WA 98223 Telephone: (360) 651-6850 Fax: (360) 651-6940 Resident Care Service Date 10/15/13	F 000	OCT 28 2013 ADSA/RCS Region 3	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/25/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	The residents have the right for the facility to thoroughly investigate alleged violations to prevent further potential abuse while the investigation is in progress.	10/31/13 - ongoing

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F 225	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure thorough investigations were done for five sample residents (Resident #1,# 2,# 3, #4, #5) regarding injuries of unknown origin and substantial injuries. The lack of a thorough investigation to determine and identify potential causes to prevent further incidents and to assist in implementing appropriate interventions placed the residents at risk for possible reoccurence of the injuries. Findings include: The facility ' s policy/procedure for investigations read: " all incidents will be thoroughly investigated upon discovery of incident " and all the facts will be analyzed. The policy indicated that phase one of the investigation would include interviewing witnesses, including assigned caregiver, caregivers in immediate area, remote or potential witnesses, roommates , observe environment, physical exam and if you did any staff training, document what was done and who was trained and list who was at the scene-even if the event was not witnessed. The policy directed staff to analyze the information collected during the initial phase (who, what, why, when, where and how questions). If unable to establish a reasonable cause or known source, an extended investigation was required. An extended investigation (Phase two) may include expanding the sample or the time frame surrounding the incident. RESIDENT 1:	F 225	The residents have the right for the facility to thoroughly investigate alleged violations to prevent further potential abuse while the investigation is in progress. Nursing Staff inserviced on the need to thoroughly investigate and report any injuries of a substantial, vulnerable nature to State reporting hotline. Nursing Staff and NAC's inserviced on proper verbage with regards to statements "Be more careful". Avoid as it insinuates staff are not being careful when providing care	10/31/13 ongoing 10/30/13 & ongoing 10/30/13 ongoing

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F 225	Continued From page 3 Resident 1 was admitted to the facility in 2008. The Minimum Data Set (MDS) assessments for 5/28/13 and 8/26/13 revealed the resident's cognition was severely impaired and she was dependent on staff for transfers, bed mobility and toileting. She had impaired range of motion in her upper extremities. The current Plan of Care(POC), dated 5/14/13, read: bruise L (left eye) and instructed staff to "place stuffed animal on left shoulder for cushioning/barrier to prevent injury to left eye as she refuses pillow." The POC revealed the resident required the use of a mechanical lift for transfers. First incident An Incident Questionnaire report dated 8/19/13, documented the resident had a "bruise, purple in color diffuse L (left) eye, reported by NAC (nursing assistant) during lunch time". The resident was unable to tell staff how the bruise to her left eye had happened. The staff checked the type of injury as a substantial injury of an unknown source and that staff would be trained/counseled. The plan to prevent further bruises to Resident 1's left eye was "to monitor and be careful during care and transfers". The report indicated the bruise likely happened from continued pressure of Resident 1's hands (knuckles) against her left eye, and directed staff to place her stuffed animal pillow as a cushion to her shoulder to prevent further injuries to the eye. The report only had one documented interview from a Nursing Assistant (NAC) who had reported the eye bruise to licensed nurse (LN). There were	F 225	Continued from pg 3 Res #1 Nursing staff and NAC's will provide resident with stuffed animal or pillow & ensure it is properly placed daily. No further injury 8/19/13- ongoing	8/19/13 ongoing

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F 225	Continued From page 4 no additional statements from other assigned care givers. The incident report also directed staff to "be careful during care and transfers". There was no documented evidence found on the investigative report regarding what specific inservice training was performed to prevent further injury or any observations of assigned care givers regarding transfer techniques for this resident. On 9/30/13 at 9:40 a.m., Resident 1 was observed seated in her wheelchair and dozing. Her head leaned toward her left shoulder and rested against a pillow. Her hands rested on her lap in a clinched fist position. There was no stuffed animal found on the resident's shoulder or in the resident's lap. During an interview with the Director of Nursing (DNS) at 1:30 p.m., on 9/30/13, she stated the bruise on Resident 1's left eye was due to "constant pressure" of her hands against her face. The plan was to offer her a stuffed animal to hold in her hands". During an additionalinterview with the DNS on 10/4/13, she verified the facility had not performed staff training/counseling even though the investigative report indicated training was completed to prevent reoccurrence of injury to the resident's eye and to ensure the plan of care was being followed. Second Incident A second incident questionnaire, dated 9/16/13, revealed a bruise was discovered on Resident 1's lower leg and was described as a superficial injury. The report revealed the origin was	F 225	Incident report revised to include additional NAC interventions for 3 previous shifts. DNS will also expand interview process to ensure root cause analysis requirements are being met. 10/22/13 ongoing Res # 1 plan of care was reviewed to ensure resident's specific interventions were in place to meet resident's needs. No further injury noted 9/30/13 - ongoing due to interventions put in place 9/30/13 ongoing	

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F 225	Continued From page 5 established and staff were educated to use "caution when pushing" her wheelchair up to dining room table and to monitor placement of her legs. This investigative report had only one interview which was obtained by a Licensed Nurse who documented Resident 1 may have sustained bruises on her leg during a transfer or from her wheelchair. The investigation indicated in order to prevent reoccurrence of bruising, staff were to be careful with transfers, be more gentle during care and to provide more frequent checks when she became restless. A nursing note entry dated 9/16, documented the bruise on her lower leg to be 7 centimeters (cm) by 10 cm in size. The investigative report did not include interviews from other care givers, observation of how the resident's positioning may relate to the bruises on her leg when positioned during meals, observations of how assigned staff were transferring her, and if interventions were appropriate when she became restless to prevent further incidents of injury. Even though Resident 1 was discovered on 8/19/13 to have a bruise to her eye, a substantial injury, and on 9/16/13 a bruise to her leg, there was no documented evidence thorough investigations were completed. Both investigative reports did not include interviews from all assigned staff who had cared for Resident 1. The investigations had conflicting data regarding how the bruises may have occurred, and there was no analysis of the information. The reports lacked documentation regarding observations of care delivery especially when the investigative report for 9/16/13 indicated staff needed to perform "careful"transfers. There was no evaluation of her positioning at the dining room table even	F 225	DNS/LN's will gather information, interview other residents & staff and observe transfers and care delivery to ensure interventions are appropriate. Will use all information gathered to draw conclusions	10/31/13 — ongoing

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F 225	Continued From page 6 though she was dependent on staff for wheelchair mobility and supervised eating. RESIDENT 2 : Resident 2 was admitted to the facility in 2011 with diagnoses of dementia and muscle weakness. The MDS assessment, dated 7/28/13, revealed she required 2 person maximum assistant for transfers with a mechanical lift and for bed-mobility. The resident weighed 170 pounds. The current Plan of Care for alterations in skin integrity informed staff to "be careful when removing/changing incontinent briefs, do not pull the brief from under her hips-can cause abrasion". On 9/30/13 at approximately 8:40 a.m., she was observed seated in her wheelchair at the breakfast table being fed by staff. A facility "Incident Questionnaire", dated 9/1/13, documented Resident 2 had a bruise on her inner thigh. The written statement from a nursing assistant documented the bruise on the thigh was "likely attributed to sling of hoyer lift as it crosses her thighs". The nurse checked the injury to be a substantial injury (bruises of deep color/depth) and also checked the injury as a superficial injury, a small bruise occurring in places generally vulnerable to trauma such as arms, forearms & shins. The Skin Impairment Sheet for September 2013 documented the bruise on her inner thigh measured 8 centimeters (cm) by 1 cm in size. The "Incident Questionnaire" and investigative forms only included a statement from one NAC on 9/1/13 who stated that a change in transfer	F 225	Res #2 LN's educated and inserviced on correct way to fill out "Incident Questionaire" if at any time resident sustains a substantial injury they are to call State hotline and report & follow/up with full investigation	10/30/13 ongoing

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F 225	Continued From page 7 technique was needed to avoid bruising to Resident 2's thigh. The investigative report was reviewed by administrative staff on 9/3/13 and read: staff reports that sling from hoyer caused the bruising to the thigh and that staff will be educated on "cradle technique when using mechanical lift". The report concluded an "origin established" for the bruise on the thigh. There was no documented evidence, the facility had evaluated other residents for possible bruises who required transfers using a mechanical (hoyer) lift or assessed caregivers during care for Resident 2. On 10/4/13, the Director of Nursing verified there was no documented evidence staff had been observed during a transfer with the use of a mechanical lift with Resident 2 or assessed other residents who may be placed at risk for injuries when transferred with a mechanical lift. On 10/4/13 at 9:05 a.m, the Licenses Nurse (LN K) stated Resident 2 who was dependent on staff for care, was transferred with the use of a mechanical lift and would sometimes exhibit anxiousness. RESIDENT 3: Resident 3 was admitted to the facility in 2012 with diagnoses including insulin dependent diabetes and dementia. The MDS, dated 8/20/13, documented he required 2 person maximum assistance with bed mobility, transfers and toileting. The Plan of Care for transfers revealed assist of 2 staff using a standing lift. Staff were to ensure his feet were flat during the transfers.	F 225	Resident #2 DNS will observe staff during care and transfers using hoyer lift. Staff enserviced and educated on correct transfer techniques. Also enserviced on proper handling/use of all lifts.	10/29/13 ongoing

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F 225	Continued From page 8 An "Incident Questionnaire", dated 9/11/13, documented the resident's left shin had 2 skin tears. One skin tear measured 9 millimeters (mm) by 9 mm in size and the other measured 8 mm by 5 mm in size. This report indicated his skin tears were possibly caused by the foot rests on his wheelchair and staff needed to ensure they are properly attached. The LN ' s written statement concluded his skin tears may have happened when Resident 3 was being transferred and the review by the administrative staff documented the skin tears may have resulted from his footrests. The Nursing Assistant Guidelines indicated the resident wore a supportive sock to his left lower extremity and a Restorative Note, dated 9/9/13, revealed he was able to self propel his wheelchair to the dining room using his hands and feet. On 10/4/13 at 8:55 a.m., Resident 3 was observed in his room seated in his wheelchair without foot pedals attached. At 2:00 p.m., he was observed in his wheelchair with his feet resting on the foot pedals. His left leg rested against the metal frame of his wheelchair and a supportive sock was observed on his left leg. Even though the facility concluded the skin tears were "reasonable related" to his footrests or during a transfer, there was no documented evidence other care givers had been interviewed, transfer techniques observed or a possible evaluation of his positioning in the wheelchair with or without footrests was completed. RESIDENT 4: Resident 4 was admitted in 2011 with diagnosis of stroke with weakness of her right side. The MDS,	F 225	Res # 3 plan of care reviewed and adjusted to include specific interventions with regards to footrests on W/c which are to be off when res is in room. Enabling them to self propel. Goal to prevent further injury - No further injury. 10/7/13 - ongoing due to interventions put into place	10/7/13 — ongoing

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F 225	Continued From page 9 dated 8/2/13, revealed the resident was dependent on staff for wheelchair mobility and required extensive assistant of 2 people for bed mobility and transfers. The quarterly assessment revealed she was able to self propel her wheelchair only short distances and was on a restorative program. On 10/4/13 she was observed seated in her wheelchair in front of the nursing station. Her right arm rested in a trough and she wore a splint on her right hand. Her left hand was contracted and a foam dressing was in her palm. Review of facility investigative report, dated 8/5/13, documented Resident 4 had a bruise on her left lower leg which measured 6 centimeter (cm) by 5 cm in size. The investigation report included only one written statement from a nursing assistant who documented that to prevent further injury, people transferring the resident "need to be careful while working with her". The report concluded the resident may have "bumped" herself and likes to sit at nurse's station that is congested and that staff would be trained/counseled. There was no documented evidence the facility had observed staff providing care for the dependent resident, interviewed other care givers, or evaluated the seating arrangement around the nursing station to ensure Resident 4 was positioned safely to prevent any further injuries. RESIDENT 5 Resident 5 was admitted to the facility in 2012 with diagnosis including dementia. The quarterly assessment, dated 8/14/13, documented he had dementia with short term memory loss, was able	F 225	Res# 4 DNS will thoroughly investigate incident reports, interviewing additional staff and other residents. will educate staff on use of proper wheelage and staying away from "be more careful" Staff will evaluate seating arrangement at nurses station. No further injury 8/5/13 - ongoing Res#5 Revised incident report to include additional interviews. will f/u with POC to ensure interventions are effective	8/5/13 - ongoing 10/30/13 ongoi

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F 225	Continued From page 10 to participate in daily dressing and was in a restorative nursing program for range of motion exercises and ambulation. An incident report, dated "unk" (unknown), indicated the resident had a skin tear to his right wrist. The report documented there was "no witnesses to incident" and staff would be educated. The facility concluded it was unknown as to how Resident 5 sustained the skin tear but he would now wear protective sleeves as he refused to prior to the incident. There was no documentation other caregivers were interviewed when the injury was unwitnessed. The investigative reports reviewed were incomplete and not thorough. They lacked an analysis of data from more than 1 caregiver, interviews from care givers, documented inservices/education, and staff assessment of other residents with similar conditions who may be at risk for injury. Reports did not document the evaluation of whether the current plan was effective and what preventive measures were needed to prevent reoccurrence of both superficial and substantial injuries.	F 225	Care plans have been updated and revised for residents 1-5. Staff have been inserviced with regards to lift use transfer/transfer techniques and personal protective equipment use. Incident report revised to facilitate more detailed investigation and root cause analysis such as comprehensive interviews, reenactments, demonstration & staff training. Focus on incident prevention with proper placement and use of equipment, in individualized care plans & training. DNS will monitor. Administrator will ensure Compliance	10/30/13 ongoing